

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-007607

STATE FILE NUMBER

AMENDED

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 63

1. FILED MAR 7 1962 a. COUNTY St. Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Charles	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St, Charles		c. CITY OR TOWN O'Fallon	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Josephs Hospital		d. STREET ADDRESS (If outside, give location) Route 2	
3. NAME OF DECEASED (Type or print) First Middle Last Robert Bauer McKee		4. DATE OF DEATH Month Day Year 2/27/62	
5. SEX M.	6. COLOR OR RACE W	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11/30/1889
9. AGE (last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance	
10b. KIND OF BUSINESS OR INDUSTRY New York Life		11. BIRTHPLACE (City and state or country) Sparta Ill.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Robert	
13b. MOTHER'S MAIDEN NAME Mary Livingston		14. NAME OF HUSBAND OR WIFE Catherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [Redacted]	
17. INFORMANT Address Catherine McKee Rt. 2 O'Fallon Mo.		18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour a.m. Month, Day, Year	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		20g. COUNTY	
20h. STATE		21. I attended the deceased from 2-27-62 to 2-27-62 and last saw him alive on 2-27-62 Death occurred at 1 AM on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE [Signature]		22b. ADDRESS O'Fallon Mo	
22c. DATE SIGNED 2-28-62		23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	
23b. DATE 3/2/62		23c. NAME OF CEMETERY OR CREMATORY Missouri Crematory	
23d. LOCATION (City, town, or county) St. Louis, Mo.		23e. STATE	
24. FUNERAL DIRECTOR Schumacher 3013 Keramec		25. DATE RECD. BY LOCAL REG. 2/28/62	
26. REGISTRAR'S SIGNATURE [Signature]		27. DATE 2/28/62	

(Licensed Embalmer's Statement on Reverse Side)

JUN 12 1962
MAY 23 1962

MAR 22 1962

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jack Haupt
Licensed Embalmer No. 4746

P. O. Address St Louis Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.